General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Archway Pharmacy, 19-21 Kimberworth Road, ROTHERHAM, South Yorkshire, S61 1AB

Pharmacy reference: 1039222

Type of pharmacy: Community

Date of inspection: 29/08/2024

Pharmacy context

The pharmacy is next to a GP surgery in a residential area of Rotherham. Its main services include dispensing NHS prescriptions, selling over-the-counter medicines and providing advice and support to people with minor ailments through the NHS Pharmacy First service. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it offers a medicine delivery service.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

Overall, the pharmacy identifies and manages the risks for the services it provides. It keeps people's confidential information secure. And it mostly keeps the records as required by law. The pharmacy advertises how people using its services can provide feedback and it effectively manages the feedback it receives. Pharmacy team members act to reduce risk following mistakes they make during the dispensing process. And they know how to raise concerns to keep vulnerable people safe from harm.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) to supports its safe and effective running. Current SOPs had been personalised for use in the pharmacy using templates provided by its head office. And they had been due for review in March 2024. The pharmacy had introduced some new SOPs as part of its risk assessment processes when it implemented new services such as the NHS Pharmacy First service. Team members knew how to access the SOPs and most team members had signed the SOPs to confirm they had read and understood them. Team members were knowledgeable about their roles and demonstrated how they worked safely when completing tasks. But a trainee team member was not entirely sure of the tasks that could take place should the RP take absence from the pharmacy and explained they had not been in this situation. They stated they would check with another team member if they were unsure.

The team used the functions of its patient medication record (PMR) system to support a series of checks throughout the dispensing process. This relied on barcode technology to complete checks during the assembly process and the final accuracy check of the medicine. A clinical check of prescriptions was required before dispensing activity could begin. The PMR flagged new medicines and changes to medicine doses or directions to the RP prior to dispensing activity beginning. The team demonstrated how the PMR alerted them of any mistakes made during the dispensing process, known as near misses. The PMR did not produce dispensing labels until a near miss was rectified. The team referred any medicines that did not scan and any queries they had during the dispensing process to the RP. The RP manually completed the final accuracy check of these medicines. The team did not generally record details of near misses which the PMR was not able to pick up, such as quantity errors. A team member demonstrated the checks they made when dispensing medicines outside of the manufacturer's original packaging. This included a second check of medicines such as those picked ready to assemble in multi-compliance packs. The team provided examples of how it acted to reduce risk following near misses. For example, it held medicines which were uncommonly used in baskets on the dispensary shelves. This reduced the risk of these medicines becoming mixed up with commonly used medicines. The pharmacy had a procedure for reporting and investigating mistakes made following the supply of a medicine to a person, known as a dispensing error. The team explained how these would be reported by using a national reporting tool. They were not aware of any dispensing errors being brought to their attention since the implementation of the new PMR system in 2023.

The pharmacy had a complaints procedure. And it advertised how people could provide feedback or raise a concern within its practice leaflet. A team member explained how they would manage feedback and refer a concern to the supervisor or RP in the first instance. Team members had responded to feedback about the pharmacy's paperless dispensing process by ensuring repeat prescription request

slips were printed and made available to people when supplying medicines. The pharmacy had a safeguarding procedure and information for local safeguarding teams was accessible to its team members. Team members engaged in various levels of safeguarding learning dependent upon their role. They provided examples of how they had worked collaboratively with other health and social care teams to support vulnerable people in accessing pharmacy services. But not all team members were familiar with code words publicised by national domestic violence safety initiatives, designed to support people in requesting access to a safe space.

The pharmacy held personal identifiable information in the staff-only area of the premises and on password protected computers. Team members engaged in information governance learning. Confidential waste was separated from other waste and team members explained this was securely disposed of. The pharmacy had current professional indemnity insurance. The RP notice displayed had the correct details of the RP on duty. A sample of other pharmacy records checked mostly met legal and regulatory requirements. The RP record was completed in full, details of private prescriptions dispensed were recorded in full within an electronic private prescription register held on the PMR system. The controlled drug (CD) register had some information missing on several page headers. The pharmacy maintained running balances in the CD register. Regular full balance audits of physical stock against the register took place. The pharmacy had a patient returned CD register and it entered returns in the register at the point of receipt.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough skilled and knowledgeable team members to manage its workload. Pharmacy team members engage in ongoing learning to support them in providing the pharmacy's services safely. They take opportunities to share learning with each other and to develop their understanding of relevant topics relevant to their roles. And they know how to raise and escalate a concern at work.

Inspector's evidence

The RP was a locum pharmacist who worked regular days at the pharmacy each week. Staffing levels and skill mix had changed since the previous inspection which took place in February 2024. Two dispensers were on long-term planned leave and the pharmacy had recruited a trainee medicine counter assistant. Team members reported working flexibly to help provide cover for planned and unplanned leave. A trainee dispenser held the role of supervisor, they were working alongside the trainee medicine counter assistant, three qualified dispensers and a pharmacy student during the inspection. The pharmacy was busy throughout the inspection, workload was up to date and managed efficiently. The pharmacy employed another pharmacy student and a delivery driver. The superintendent pharmacist (SI) and the pharmacist manager, who was a director for the company, also worked at the pharmacy.

Trainee team members were progressing through GPhC accredited training courses relevant to their role. They received support at work for their learning and development through regular discussions with their manager. And they were confident in making requests for specific learning. For example, a team member had asked to undertake vaccination training to support their development. And this training need had been met ahead of the flu vaccination season beginning. Pharmacy team members were not required to meet specific targets. They were encouraged to use their learning to support the safe delivery of pharmacy services. And they regularly shared learning with each other to support this approach. For example, a pharmacy student had shared information with a dispenser about how to recognise commonly prescribed medicines to treat high-blood pressure. The dispenser explained this helped them to identify people who were already on blood pressure treatment and would not be eligible for the NHS blood pressure check service.

Team members engaged with each other through regular conversations during the working day. This included morning briefings to discuss workload and regular discussions about patient safety and stock management. Dispensary team members rotated around different tasks to ensure they were competent in completing a range of different activities. The pharmacy had a whistleblowing policy and team members were confident in sharing feedback with each other and with the pharmacist manager and SI. They knew how they could escalate concerns if needed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are safe and secure. They provide an appropriate environment for delivering healthcare services. People visiting the pharmacy can speak to a team member in confidence in a private consultation room.

Inspector's evidence

The pharmacy was secure and generally well maintained. Pharmacy team members knew how to raise maintenance concerns and discussed recent works conducted to address an outstanding concern following the roof leaking in severe weather. There was some cosmetic work required in a corridor due to previous water damage. The pharmacy completed periodic health and safety risk assessments. It had fire safety assessments from an external company. And it had acted on advice provided following recent power surges in the area. The pharmacy was clean and organised. Team members had access to sinks equipped with hand washing facilities. The dispensary sink was mostly used by team members when preparing liquid medicines. Lighting was bright throughout the premises and air conditioning controlled the temperature.

The public area of the pharmacy was fitted with wide spaced aisles. The dispensary was accessed down a short flight of stairs leading from behind the medicine counter. Pharmacy team members escorted people to and from the consultation room as the door to the room was behind the medicine counter. The room was clean and professional in appearance. People accessing some services attended a hatch at the back of the pharmacy. This hatch led to a room off the dispensary, team members responded promptly to people knocking on the hatch for assistance. Team members used workspace in the dispensary well with dedicated areas for completing different tasks, such as the assembly of multi-compartment compliance pack service. Off the dispensary was a corridor with storage space for dispensary sundries, staff facilities and a good-sized stock room.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. It obtains its stock from reputable suppliers. And its team members make regular checks to ensure medicines are safe to supply to people. Pharmacy team members work well with other healthcare providers to ensure people receive the care and support they need. And overall, they provide relevant information when supplying medicines to people.

Inspector's evidence

People accessed the pharmacy from street level. The pharmacy advertised its opening hours. And information about the services it provided. A television screen near the medicines counter provided valuable information to people about the pharmacy's services. The pharmacy protected Pharmacy (P) medicines from self-selection by displaying these behind transparent plastic screens in the public area. There was signage advising people to seek the assistance of team members when requesting a P medicine. A team member discussed safety flags that appeared on the pharmacy till when selling P medicines to ensure team members asked appropriate questions to help determine a medicine was suitable for a person to use. Team members knew to refer repeat requests for higher-risk P medicines liable to abuse to the RP.

One of the pharmacy's busiest services was the Pharmacy First consultation service. The pharmacy worked well with the local surgery who actively referred people to the service. And the pharmacy and surgery had agreed some additional steps the pharmacy could take to support people in receiving timely and appropriate care. This included completing some routine throat swabs for people accessing the sore throat service and support for people accessing the urinary tract infection service by providing a urine sample container with instructions of when to take a sample into the GP surgery for testing. The pharmacy provided urine sample pots to people who did not meet the Pharmacy First inclusion criteria for the service and advised they take a sample into their GP surgery as soon as possible. The RP completed an initial screening of the referrals into the service. And arranged face-to-face appointments with people for a mutually convenient time, on the same day. They made effective consultation notes, including details of the discussions they had with people about the actions they should take if their symptoms worsened. And they referred people to appropriate healthcare providers when the pharmacy could not support a care. For example, when a person presented with symptoms which indicated urgent hospital treatment was required. The team had supportive information available to support the safe delivery of this service, including current versions of the national patient group directions.

The team used the PMR to help identify some higher-risk medicines during the dispensing process. And team members provided examples of how these were highlighted to prompt them to refer to the RP for counselling. Team members were aware of medicines requiring supply in the manufacturers original packaging, including valproate. But the pharmacy had not completed a formal risk assessment when it identified exceptional circumstances requiring it to make a supply of valproate outside of the manufacturer's original packaging. This practice was not in line with the requirements of the valproate pregnancy prevention programme (PPP). A discussion highlighted this requirement and the RP provided assurances that risk assessments would be put in place as required by the PPP. The RP had access to a range of tools to support them in providing counselling to people when supplying higher-risk medicines.

And they were aware of the counselling requirements of medicines with PPPs. But these types of verbal interventions were not recorded on the PMR to support continual care.

The pharmacy team used a series of audit trails to support it in delivering its dispensing services. This included team members using individual login details on the PMR system to take ownership of the tasks they completed. And applying their dispensing signature to backing sheets attached to multi-compartment compliance packs. The pharmacy kept a record of the medicines it owed to people, and of the medicines it delivered to people. The pharmacy's delivery application provided real-time information to team members. This supported them in answering any queries about the service which arose. Pharmacy team members used baskets during the dispensing process to help keep individual prescriptions separate. Pharmacists transcribed information to the PMR system when dispensing hand-written prescriptions. Team members were responsible for applying a separate check of this information during the dispensing process. Pharmacists also transcribed information from prescriptions to the pharmacy's automated dispensing machine to support the safe supply of medicines to people on opioid treatment programmes. The team effectively monitored the supply of these medicines and communicated with prescribers and people's key workers when needed. The pharmacy used a schedule to support it in managing work when supplying medicines in multi-compartment compliance packs. Team members used the PMR system to support it in supplying medicines in this way. A team member demonstrated the checks they made to check and record changes to people's medication regimens. A sample of compliance packs found clear descriptions on the attached backing sheets. But patient information leaflets were not always provided. This meant people may not have the most current information available to support them in taking their medicines safely.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It stored medicines in an orderly manner and within their original packaging. The pharmacy held medicines subject to safe custody in legally compliant cabinets. It held medicines requiring cold storage in suitable fridges equipped with thermometers. The pharmacy kept temperature records for the fridges which showed they were operating within the required range of two and eight degrees Celsius. The team had recently introduced a record to support it in recoding the checks it made to ensure medicines were safe to supply to people. The record showed regular checks of medicine expiry dates taking place. A random check of dispensary stock found no expired medicines. Team members annotated bottles of liquid medicines with their date of opening. This prompted checks to ensure any medicine remaining in a bottle was safe to dispense. The pharmacy held medicine waste away from stock medicines. It had appropriate medicine waste receptacles and CD denaturing kits available to support it in disposing of medicines safely. The team received medicine alerts through email. It acted on the alerts in a timely manner, and it retained details of the alerts to later refer to if a query arose.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it requires for providing its services. It maintains its equipment appropriately. And pharmacy team members use the equipment and facilities in a way which protects people's confidentiality.

Inspector's evidence

Pharmacy team members had access to the internet and a range of references resources held electronically. They used individual passwords and NHS smart cards when accessing people's medication records. The team stored bags of assembled medicines safely within the dispensary. Information on bag labels could not be seen from the public area of the pharmacy. Team members used handheld smart devices to scan bags of assembled medicines to shelves and when delivering medicines to people. The device used by the delivery driver was returned to the pharmacy at the end of the delivery run. The pharmacy had cordless telephone handsets which allowed team members to move to a quiet area when having a confidential conversation with people over the telephone.

The pharmacy had a range of equipment to support it in delivering its services. Equipment to support the delivery of consultation services, including the Pharmacy First Service was from recognised manufacturers and stored appropriately in the consultation room. The equipment was routinely checked and cleaned between use and single-use consumables such as earpieces for use with the otoscope were readily available. Pharmacy team members had access to personal protective equipment, including facemasks and single-use gloves. The pharmacy had a service contract for the automated dispensing machine and team members completed calibration checks of this machine daily. The pharmacy had a range of clean counting and measuring equipment for liquids, tablets, and capsules. Its electrical equipment was annotated with details of portable appliance testing that had taken place in July 2024.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.